PRINTED: 11/19/2012
FORM APPROVED

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TN4704 | A. BUILDING _____ B. WING _____ | 11/15/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FORT SANDERS TCU | 1901 CLINCH AVE KNOXVILLE, TN 37916 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 002 | 1200-8-6 No Deficiencies<br><br>During annual Licensure survey conducted on November 13-15, 2012, at Fort Sanders TCU, no deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes. | N 002 | | |

Division of Health Care Facilities

Keith A. Albrecht

TITLE CAD

(X6) DATE 30 Nov 12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

FORM NM1N11

If continuation sheet 1 of 1

STATE FORM